

SUMMARY SHEET  
SOUTH CAROLINA BOARD OF HEALTH AND ENVIRONMENTAL CONTROL

May 11, 2017

( ) ACTION/DECISION

( X ) INFORMATION

**I. TITLE:** Health Regulation Administrative and Consent Orders.

**II. SUBJECT:** Health Regulation Administrative Orders, Consent Orders, and Emergency Suspension Orders for the period of February 1, 2017, through March 31, 2017.

**III. FACTS:** For the period of February 1, 2017, through March 31, 2017, Health Regulation reports six (6) Consent Orders, and three (3) Emergency Suspension Orders with a total of forty-four thousand seven hundred fifty dollars (\$44,750) in assessed monetary penalties.

Health Regulation Bureau	Health Care Facility, Provider or Equipment	Administrative Orders	Consent Orders	Emergency Suspension Orders	Assessed Penalties
Health Facilities Licensing	Community Residential Care Facility	0	4	0	\$42,700
	In-Home Care Provider	0	1	0	\$1,250
Radiological Health	Chiropractic X-Ray Facility	0	1	0	\$800
EMS & Trauma	Paramedic	0	0	1	\$0
	Ambulance Services Provider	0	0	1	\$0
	EMT	0	0	1	\$0
<b>TOTAL</b>		<b>0</b>	<b>6</b>	<b>3</b>	<b>\$44,750</b>

Approved By:

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Shelly Bezanson Kelly  
Director of Health Regulation

HEALTH REGULATION ENFORCEMENT REPORT  
SOUTH CAROLINA BOARD OF HEALTH AND ENVIRONMENTAL CONTROL

May 11, 2017

**Bureau of Health Facilities Licensing**

Facility Type	Total # of Beds or Participants	Total # of Licensed Facilities in South Carolina
Community Residential Care Facility	17,989	467
In-Home Care Provider (Unlicensed)	N/A	528

**1. Magnolias of Gaffney Assisted Living Community (CRCF) – Gaffney, SC**

Investigation: The Department visited Magnolias of Gaffney Assisted Living Community (“Magnolias”) on January 6, 2015, to conduct a general inspection, January 26, 2016, to conduct a general and food and sanitation inspection, March 8, 2016, to conduct a fire and life safety inspection, and June 21, 2016, for a follow-up inspection.

Violations: Based upon the inspections, the Department cited Magnolias for fifty-four (54) violations of Regulation 61-84, Standards for Licensing Community Residential Care Facilities. Specifically, Magnolias was cited one (1) time for violating Section 502.C, by failing to designate a staff member in writing to act in the absence of the administrator; eighteen (18) times for violating Section 504.A, by failing to maintain required documentation evidencing inservice training; one (1) time for violating Section 505.A, by failing to have documentation of a health assessment for a staff member available for review; one (1) time for violating Section 604, by failing to notify the Department within seventy-two (72) hours of a change in administrator; one (1) time for violating Section 702, by failing to have documentation of written assessments available for review and by failing to conduct written assessments within seventy-two (72) hours of residents’ admissions; seven (7) times for violating Section 703, by failing to update and maintain residents’ ICPs; two (2) times for violating Section 801, by failing to retain only appropriate residents and failing to adequately coordinate a resident’s transfer; one (1) time for violating Section 901.C, by failing to render care and services to residents in accordance with the orders from physicians or other authorized healthcare providers; one (1) times for violating Section 1101.A, by failing to have documentation of a current annual physical examination for a resident and by failing to ensure residents’ physical examinations were completed within thirty (30) days prior to admission; two (2) times for violating Section 1101.B, by failing to maintain documentation of residents’ TB tests available for review; two (2) times for violating Section 1205.A, by failing to maintain appropriate labeling on a resident’s medication container; three (3) times for violating Section 1206, by failing to comply with medication review and storage requirements; one (1) time for violating Section 1301.A, by failing to comply with the requirements of Regulation 61-25, Retail Food Establishments; five (5) times for violating Section 1702, by failing to follow requirements for TB testing; three (3) times for violating Section 1703, by failing to follow appropriate housekeeping requirements and failing to safely store harmful chemicals and cleaning materials; two (2) times for violating Section 2206.B (2012) and Section 2104.A (2016), by failing to adequately secure oxygen cylinders; one (1) time for violating Section 2301.B, by failing to ensure that plumbing fixtures that require hot water and are accessible to residents were supplied with water of at least one hundred (100) degrees Fahrenheit; and two (2) times for violating Section 2601.D (2012) and Section 2501.C (2016), by failing to ensure that HVAC supply or return grilles were not installed within three (3) feet of a smoke detector.

Enforcement Action: Pursuant to the Consent Order executed February 23, 2017, the Department assessed a twenty-five thousand seven hundred dollar (\$25,700) monetary penalty against Magnolias. A term of the Consent Order required Magnolias to pay fifteen thousand dollars (\$15,000) of the assessed penalty. The assessed penalty was received February 15, 2017.

Prior Sanctions: None.

## **2. Oakleaf Village at Thornblade (CRCF) – Greer, SC**

Investigation: The Department visited Oakleaf Village at Thornblade (“Oakleaf”) on March 3, 2016, and September 23, 2016, to conduct complaint investigations, and June 29, 2016, to conduct a general inspection.

Violations: Based upon the inspections, the Department cited Oakleaf for twelve (12) violations of Regulation 61-84, Standards for Licensing Community Residential Care Facilities. Specifically, Oakleaf was cited one (1) time for violating Section 401, by failing to follow its policy and procedure in reporting and documenting an incident involving a resident; one (1) time for violating Section 501.A, by failing to have documentation of a criminal background check for staff members available for review; one (1) time for violating Section 504.A.4, by failing to have documentation of initial training in medication management and administration for new staff members available for review; one (1) time for violating Section 601.A, by failing to have documentation of an internal investigation of an incident involving a resident; one (1) time for violating Section 701.B.6, by failing to have notes of observation for residents documented at least monthly available for review; one (1) time for violating Section 702, by failing to develop residents' written assessments within seven (7) days of admission; one (1) time for violating Section 703.A, by failing to review and/or revise residents' ICPs at least semi-annually; one (1) time for violating Section 901.C, by failing to administer a resident's medication as prescribed by a physician; one (1) time for violating Section 1001.A, by failing to comply with S.C. Code Section 44-81-40(G) with regard to a resident's rights and protections; one (1) time for violating Section 1101.A, by failing to have documentation of residents' current annual physical examinations available for review; one (1) time for violating Section 1201.A, by failing to have residents' medications prescribed by a physician or other authorized healthcare provider available for administration; and one (1) time for violating Section 2301.B, by failing to ensure that hot water temperatures in a resident's shower did not exceed one hundred twenty (120) degrees Fahrenheit.

Enforcement Action: Pursuant to the Consent Order executed February 21, 2017, the Department assessed a six thousand one hundred dollar (\$6,100) monetary penalty against Oakleaf. The assessed penalty was received February 15, 2017.

Prior Sanctions: None.

## **3. Carolina Gardens at Harbison (CRCF) – Irmo, SC**

Investigation: The Department visited Carolina Gardens at Harbison (“Carolina”) on August 18, 2016, to conduct a general inspection, and August 19, 2016, to conduct a complaint investigation.

Violations: Based upon the inspections, the Department cited Carolina for seven (7) violations of Regulation 61-84, Standards for Licensing Community Residential Care Facilities. Specifically, Carolina was cited one (1) time for violating Section 401 on August 19, by failing to implement its policies and procedures concerning the return of an eloped resident; two (2) times for violating Section 901.C, by failing to administer residents' medications as prescribed by a physician or other authorized healthcare provider and by failing to take precautions for a resident with special conditions; one (1) time for

violating Section 1203.F, by failing to ensure that documented reviews of MARs were conducted by outgoing staff members with incoming staff members at shift changes; one (1) time for violating Section 1206.C.2, by failing to ensure that documented reviews of control sheets were conducted by outgoing staff members with incoming staff members at shift changes; one (1) time for violating Section 1702.A, by failing to ensure that a resident's TB test was examined for induration within forty-eight to seventy-two (48–72) hours after administration; and one (1) time for violating Section 2104.A., by failing to conspicuously post no smoking signs in rooms where oxygen cylinders were being stored and used.

Enforcement Action: Pursuant to the Consent Order executed March 14, 2017, the Department assessed a four thousand eight hundred dollar (\$4,800) monetary penalty against Carolina. The assessed penalty was received April 25, 2017.

Prior Sanctions: None.

#### **4. Sweetgrass Village Assisted Living Community (CRCF) – Mount Pleasant, SC**

Investigation: The Department visited Sweetgrass Village Assisted Living Community (“Sweetgrass”) on May 6, 2015, and June 22, 2016, to conduct complaint investigations, and January 5, 2016, to conduct a general inspection.

Violations: Based upon the inspections, the Department cited Sweetgrass for seven (7) violations of Regulation 61-84, Standards for Licensing Community Residential Care Facilities. Specifically, Sweetgrass was cited one (1) time for violating Section 504.A, by failing to ensure that documentation of inservice training was signed by the individual receiving the training; one (1) time for violating Section 702, by failing to complete residents' written assessments no later than seventy-two (72) hours after admission; one (1) time for violating Section 703.A, by failing to have documentation of residents' current ICPs available for review, by failing to ensure residents' ICPs were developed within seven (7) days of admission, and by failing to ensure residents' ICPs were signed by the resident and/or the sponsor or responsible party, when appropriate; one (1) time for violating Section 901.B, by failing to coordinate with a resident or the resident's responsible party to ensure that the resident receives routine care as ordered by a physician or other authorized healthcare provider; one (1) time for violating Section 901.C, by failing to render care and services to a resident in accordance with orders from a physician and by failing to take precautions for a resident with special conditions; one (1) time for violating Section 1101.A, by failing to have documentation of residents' current annual physical examinations available for review; and one (1) time for violating Section 1206.C.2, by failing to maintain records of receipt, administration, and disposition of a controlled substance in sufficient detail to enable an accurate reconciliation.

Enforcement Action: Pursuant to the Consent Order executed March 17, 2017, the Department assessed a six thousand one hundred dollar (\$6,100) monetary penalty against Sweetgrass. The assessed penalty was received March 30, 2017.

Prior Sanctions: None.

#### **5. Samaritan Bed and Bath Services, Inc. (IHCP) – Travelers Rest, SC**

Investigation: The Department visited Samaritan Bed and Bath Services, Inc. (“Samaritan”) on June 1, 2016, to conduct a complaint investigation.

Violations: Based upon the investigation, the Department cited Samaritan for violating Section 103.A of Regulation 61-122, for establishing, operating, maintaining, and representing itself through advertising and/or marketing as an in-home care provider without first obtaining a license from the Department.

Enforcement Action: Pursuant to the Consent Order executed March 17, 2017, the Department assessed a one thousand two hundred fifty dollar (\$1,250) monetary penalty against Samaritan. The assessed penalty was received April 12, 2017.

Prior Sanctions: None.

**Bureau of Radiological Health**

Facility Type	Total # of Registered Providers in South Carolina
Chiropractic X-Ray Facilities	487

**6. Hudak Chiropractic & Wellness Center, P.C. (Chiropractic Facility) – Murrells Inlet, SC**

Investigation: On June 30, 2010, the Department conducted a routine inspection of Hudak Chiropractic & Wellness Center, P.C. (“Hudak”) and found the facility in violation of Regulation 61-64, X-Rays (Title B), for failure to perform equipment performance testing, which is required every two (2) years. On August 26, 2010, Hudak submitted evidence of acceptable equipment performance testing. On September 11, 2013, the Department conducted another routine inspection and determined that Hudak did not do equipment performance testing in 2011 or 2012, as required. Hudak subsequently submitted evidence of acceptable equipment performance testing on October 22, 2013. Finally, the Department conducted another routine inspection on September 29, 2016, and determined Hudak’s last equipment performance testing was September 25, 2013.

Violations: Based upon the above-referenced inspections, the Department finds Hudak in violation of RHB 4.2.16.1 on June 30, 2010, September 11, 2013, and September 29, 2016, by failing to complete equipment performance testing at the required intervals.

Enforcement Action: By Consent Order executed March 14, 2017, Hudak agrees to the imposition of an eight hundred dollar (\$800) civil penalty. The Consent Order requires Hudak to make payment of two hundred dollars (\$200) of the assessed monetary penalty within thirty (30) days of execution of the Consent Order. The remaining six hundred dollars (\$600) of the assessed penalty will be stayed upon a twenty-four (24) month period of substantial compliance with R.61-64 and the terms of the Consent Order. The Consent Order further requires Hudak to provide the Department with documentation detailing how they will ensure that compliance with R.61-64 is maintained. This documentation was submitted by Hudak at the January 24, 2017, enforcement conference. Finally, Hudak agreed to correct the violations that resulted in the Consent Order.

Prior Sanctions: None.

**Bureau of EMS & Trauma**

<b>EMS Provider Type</b>	<b>Total # of Providers in South Carolina</b>
EMT	5,647
EMT – Intermediate	196
Advanced EMT	366
Paramedic	3,645
Athletic Trainers	889
Ambulance Services Provider	257
First Responder Services Provider	2

**7. Liza D. Hudson (Paramedic)**

Investigation: On January 23, 2017, the Department was notified of Ms. Hudson’s arrest in Chesterfield County. Upon notification, the Department initiated an investigation into the matter. The Department discovered that Ms. Hudson was arrested on January 20, 2017, and charged with theft of a controlled substance, and two (2) counts of violation of drug distribution law, imitation controlled substance.

Violations: The felony charges against Ms. Hudson are crimes involving drugs, moral turpitude, or gross immorality and therefore rise to the level of misconduct as prescribed in S.C. Code Section 44-61-80(F)(2) and Regulation 61-7, Section 1100(B)(2). The Department believes Ms. Hudson’s arrest demonstrates a capacity for inappropriate and criminal behavior towards individuals placed within her trust.

Enforcement Action: Ms. Hudson’s Paramedic certificate was immediately suspended on an emergency basis pursuant to the Emergency Suspension Order executed January 25, 2017. The Department will continue to monitor Ms. Hudson’s criminal matters.

Prior Sanctions: None.

**8. Randy W. Cannon, Jr. (EMT)**

Investigation: On February 2, 2017, the Department was notified of Mr. Cannon’s arrest in Berkeley County. Upon notification, the Department initiated an investigation into the matter. The Department discovered that Mr. Cannon was arrested on January 26, 2017, and charged with two (2) counts of second degree arson.

Violations: The felony charges against Mr. Cannon are crimes involving drugs, moral turpitude, or gross immorality and therefore rise to the level of misconduct as prescribed in S.C. Code Section 44-61-80(F)(2) and Regulation 61-7, Section 1100(B)(2). The Department believes Mr. Cannon’s arrest demonstrates a capacity for inappropriate and criminal behavior towards individuals placed within his trust.

Enforcement Action: Mr. Cannon's EMT certificate was immediately suspended on an emergency basis pursuant to the Emergency Suspension Order executed February 3, 2017. The Department will continue to monitor Mr. Cannon's criminal matters.

Prior Sanctions: None.

#### **9. Fast Break Transportation, LLC (Ambulance Services Provider)**

Investigation: Fast Break Transportation, LLC ("Fast Break") is a licensed provider of ambulance services in South Carolina. On March 9, 2017, the Department received notification from Fast Break's medical control physician indicating he discontinued serving as Fast Break's medical control physician on March 3, 2017. The Department attempted to communicate with Fast Break regarding retention of a medical control physician. However, the Department has not received any response from Fast Break.

Violations: The Department determined Fast Break violated S.C. Code Sections 44-61-40(C) and 44-61-70(B)(4), and Regulation 61-7, Section 402, by failing to maintain a medical control physician. Further, the Department determined Fast Break violated R.61-7, Section 402(E), by failing to notify the Department of a change in its medical control physician within ten (10) days. Based upon these violations, the Department determined that Fast Break's ambulance services provider license shall be immediately suspended, unless and until Fast Break retains a medical control physician.

Enforcement Action: Pursuant to the Emergency Suspension Order executed March 14, 2017, Fast Break's license to provide ambulance services is suspended. During the suspension, Fast Break shall not perform the functions associated with its license. Upon presenting the Department with satisfactory evidence of Fast Break's retention of a licensed physician to serve as its medical control physician, the Department will lift the Emergency Suspension Order.

Prior Sanctions: None.